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ROLES AND RESPONSIBILITIES OF CLINICAL FACULTY IN SELECTED EDUCATIONAL LEADERSHIP PROGRAMS

Educational leadership programs often are criticized for being disconnected from administrative practice, with concerns expressed regarding the paucity of professors with administrative experience (Bredeson, 1996; Levine, 2005). Although practitioners assert that professors must connect with the field, academics traditionally are rewarded for scholarly research. The university culture discourages faculty from working with schools (Young, Petersen, & Short, 2002), and untenured professors who engage in field activities often do so at the peril of their academic careers (McCarthy, 1999).

Acknowledging practitioner credibility concerns, in 1987 the National Commission on Excellence in Educational Administration (NCEEA) recommended employing clinical professors in leadership preparation programs. The NCEEA stopped short of describing how these clinical positions would be conceptualized and structured although the report noted that some individuals could be practicing administrators and that clinical faculty could teach practice-oriented courses, develop mentoring programs, and supervise internships (NCEEA, 1987). Many programs currently employ administrators as adjunct instructors to address the clinical faculty goal (Shakeshaft, 2002), but the effectiveness of the adjunct model has been questioned in promoting effective school-university connections (Schneider, 2003). Trends indicate an overuse of part-time adjuncts, which can significantly diminish program quality (Levine, 2005).

In recent years, in response to state program mandates, increased national accreditation requirements, and increasing pressure from practitioners, educational leadership programs have begun to emphasize field-based elements within their curricula (Young et al., 2002). When addressing these requirements, Young et al. (2002) recommended that institutions consider expanding the number and types of faculty members to complement existing tenure-track lines. The full-time clinical position represents a feasible alternative that has been implemented within some educational leadership programs, but little research has been conducted on the clinical faculty appointment. Position responsibility statements may not exist, role ambiguity can be a source of frustration, and conflicts can occur when clinicians in newly created positions assume duties perceived to exceed the boundaries of their authority.

This article explores the full-time clinical faculty position in selected educational leadership programs. Due to a gap in the literature, the need exists to engage in research studies to gain a greater understanding of this position. Questions guiding this study included: What is the experiential background of individuals who assume full-time clinical positions, and what factors influenced them to assume these positions? How have clinical positions been conceptualized within the overall faculty structure, and do clinical faculty members' perceptions of their roles align with their respon-

sibilities? Finally, what institutional factors influence clinical faculty members' feelings of their status and value as contributing members of their institutions? This article begins with a brief review of literature pertaining to clinical faculty in colleges of education and presents job choice theory as a theoretical framework to examine individuals' attraction to this position. It then presents the results of a qualitative study of full-time clinical faculty in education administration, discusses implications, and provides recommendations for the clinical position.

Review of Literature and Theoretical Framework

Professional school models have been embraced in some disciplines, such as law and medicine, to assist students with theory-to-practice connections, and clinical faculty appointments have been created to support this model. The NCEEA (1987) advocated that education administration preparation programs also should adopt the professional school approach, to emphasize both theoretical and clinical knowledge, applied research, and supervised practice. In contrast with traditional professorships, clinical faculty positions "are more oriented to practice than to research" (Hearn & Anderson, 2001, p. 126). Scholarly productivity often is not expected of clinicians, and positions may be perceived to hold lesser status than tenure-line appointments (Hearn & Anderson, 2001). Despite these concerns, the NCEEA (1987) advanced the argument that leadership preparation quality would be improved through a model that more fully incorporated clinical aspects into its leadership training methods.

Within schools of education, clinicians typically have been employed in teacher education programs. These individuals often are experienced teachers and administrators hired as part-time student teaching supervisors (Hearn & Anderson, 2001). Education clinicians typically earn less than their tenure-track colleagues, and they often are perceived as holding lesser status than clinical faculty working in other professional schools (Hearn & Anderson, 2001). Cornbleth and Ellsworth (1994) noted a trend in the mid-1980s toward the establishment of full-time and part-time clinical lines in teacher education, to infuse practitioner skills into the curriculum. Such positions could ease tenure-track workloads while enhancing the status of PK–12 teachers employed in part-time roles. Hearn and Anderson (2001) reported tremendous nationwide variation among clinical faculty in education colleges because these faculty operate in ill-defined positions. They recommended that clinicians be more connected to the university culture and tenure-track faculty more engaged in issues of practice.

Clinical Faculty in Educational Leadership

In 1988 Griffiths, Stout, and Forsyth proposed an educational leadership faculty model, including both tenure-track and clinical faculty in full-time lines, with delineations in focus appropriate for a professional school. Describing clinical faculty as field specialists, Griffiths et al. (1988) explained that their focus would be in schools:

> They would supervise interns, run the weekly intern seminars, and coordinate opportunities for colleagues and students to solve problems in the field. Their research would center on applied studies, the effects of administrator intervention, and case analysis. These professors might also teach field-study methods, case analysis, and other clinical studies. Despite the nontraditional nature of these roles, all professors would be expected to produce new knowledge directly related to school administration. (p. 300)

The Griffiths et al. (1988) clinical faculty definition does not appear to have gained universal acceptance among educational leadership program faculties. Instead, clinical appointments are reported to vary greatly, depending on the unique needs of the individual program. Reviewing faculty structures at Stanford University, the University of North Carolina at Chapel Hill, and the University of Utah, Bredeson (1996) noted that each had developed unique ways to staff their faculties with clinicians. He asserted that overall faculty credibility was enhanced because these individuals brought significant administrative experience to their positions.

Although no national studies exist that specifically describe characteristics of clinical faculty in educational leadership programs, several studies of educational leadership tenure-track professors have been conducted over the past 40 years (e.g., Campbell & Newell, 1973; Hills, 1965; McCarthy & Kuh, 1997; McCarthy, Kuh, Newell, & Iacona, 1988; Newell & Morgan, 1980). These studies could provide a perspective against which the experiential background and educational preparation of clinical faculty may be assessed; however, the most recent comprehensive study of tenure-track faculty was conducted over 10 years ago and may not be fully representative of faculty in the twenty-first century. In that study, McCarthy and Kuh (1997) found that tenure-line faculty turnover had been significant during the 1984–1994 timeframe, with the majority of professors hired during this period. The mean age of professors was 54 years, 29% were women, and 13% were minorities. Only one-third had been administrators, despite the fact that administrative experience was preferred. Program heads noted increased field-based connections were their most significant recent development but acknowledged that these relationships had created tensions for faculty who were expected to maintain high levels of research productivity.

More recently, Levine (2005) reported the results of his survey of full-time educational leadership faculty, and his data indicated that fewer faculty members have prior administrative experience. Only 6% had served as principals and 2% had superintendency experience. Consistent with McCarthy and Kuh's (1997) findings, professors in research universities disclosed that they were discouraged from being involved in schools because "scholarly pursuits were prized over school service" (Levine, 2005, p. 38). However, Levine also noted that, in institutions that emphasize teaching over research productivity, faculty also lacked sufficient time to become involved with local schools because their work schedules were consumed with a host of responsibilities including large classes, heavy course loads, substantial committee work, and commuting to distant off-campus teaching sites.

Two studies have examined part-time educational leadership clinical faculty. Hart and Naylor (1992) noted that conflicts surfaced when clinicians concurrently served as school leaders. Clinicians perceived they provided legitimacy to a program that became isolated as tenure-track faculty focused on research and ignored practitioner relationships. They voiced role ambiguity and uncertainty about participation in program restructuring, unless they were given explicit invitations to participate by tenure-track faculty members. Time demands resulted in uneven performance levels when clinicians' administrative positions took precedence over clinical assignments. Faculty autonomy also hindered the socialization of clinical faculty, contributing to role ambiguity. Seeking to identify work incentives, Pounder (1994) surveyed applicants for part-time clinical appointments created to coordinate field-based activities for a western university's Doctor of Education degree program. Applicants, who were practicing administrators, wished to prepare aspiring leaders, desired creativity and intellectual stimulation, and sought professional development. Pounder concluded that one's career stage may influence the effectiveness of incentives: Veteran administrators may desire stimulation and change, while administrators early in their administrative careers may seek professional recognition.

Because of the paucity of research on educational leadership clinical positions, investigation into this faculty line is warranted. In addition to determining how this position is variously defined and structured in educational leadership programs, it is desirable to identify factors that attract individuals into this professorial path.

Job Choice Theory

Job choice theory was used as the theoretical framework for this study. Proposed by Behling, Labovitz, and Gainer (1968), this theory was developed to explain factors influencing individuals' career choices and was applied to education by Young, Rinehart, and Place (1989). Job seekers' decision-making processes regarding position vacancies are influenced by two factors: their decisions to submit an application and ultimately accept the position, and their perceptions of the quality of the position (Schwab, Rynes, & Aldag, 1987). Behling et al. (1968) advanced three different theoretical constructs related to job choice: objective theory, subjective theory, and critical contact theory.

Objective theory. Objective theory postulates that job seekers identify and accept positions for economic benefits (Young et al., 1989). Employees receive varied incentives: salary, pensions, advancement opportunities, and travel funds for conference attendance. Insufficient compensation has been found to be a significant barrier in filling high school principalships, and increased stress and time demands have been noted as disincentives (Educational Research Service, 1998; Pounder & Merrill, 2001). Salary also may be a concern for professors who forego or relinquish lucrative school district salary and benefits packages. Pounder, Crow, and Bergerson (2004) estimated that decisions to become profes-

sors resulted in $13,500 annual pay cuts, when compared with those who selected administrative career paths.

Subjective theory. The job seeker's psychological needs are postulated by subjective theory. The candidate weighs perceptions of the organizational environment, choosing the position best matching her/his emotional needs (Behling et al., 1968). Pounder and Young (1996) explain an administrative candidate may select a district that emphasizes democratic leadership principles rather than bureaucratic leadership. One's desire to positively influence the educational process also would be a subjective factor (Pounder & Merrill, 2001). In their examination of the desirability of the educational leadership professorate, Pounder et al. (2004) found that the "favorable influence of teaching and opportunity to influence the profession" (p. 522) were positive factors.

Critical contact theory. Critical contact theory suggests applicants cannot differentiate between positions based only upon subjective or objective factors because they lack sufficient experience by which to evaluate the job (Behling et al., 1968). Limited application and interview data therefore inform the applicants' decision-making processes (Schwab et al., 1987), including such factors as recruiter behavior and appearance, organizational facilities, and application process efficiency (Behling et al., 1968). Pounder et al. (2004) noted applicants for professorships already may have internalized institutional norms, and experienced socialization occurring in research universities, and may be prepared to reach informed job choice decisions.

Method

This qualitative study describes characteristics of selected educational leadership clinical faculty members and their job choices, roles and responsibilities, and perceptions regarding their positions. Individuals identified for this study worked as full-time clinical faculty members in educational administration doctoral programs classified as Doctoral/Research-Extensive universities by the Carnegie Foundation for the Advancement of Teaching (McCormick, 2001); this study was conducted immediately before the Carnegie Foundation released their revised institutional classifications in 2005. Part-time adjuncts were excluded, as well as visiting professors if such positions were placeholders for tenure-track vacancies. A purposive sampling strategy was used to ensure heterogeneity with regard to institutional diversity and gender representation (Patton, 2002). Thirteen individuals were invited to participate and eight consented (two females, six males).

Data were gathered through telephone interviews, with care taken to build rapport (Berg, 2004). Interview protocol was a semi-structured format, permitting more in-depth probing into participants' narratives. Protocol was provided in advance to the participants, through electronic mailings. Interviews averaged 48 minutes (range 40 to 70 minutes). Participants also forwarded institutional policies related to their clinical faculty positions.

Interviews were audiotaped and transcribed, with personal identification information removed. Transcriptions then were returned for member checks (Glesne, 1999), and three participants returned transcripts with minor edits. The constant comparative method was used for data analysis. Each transcript was read twice, with open coding employed to categorize interview data (Patton, 2002). Emergent themes were identified for each participant, compared across participants, and common themes identified. Tentative themes were shared with participants and additional feedback was solicited, ensuring themes embodied these individuals' perceptions.

Results

This section provides an overview of the characteristics of the participants and presents common themes emerging from interviews. Anonymous quotations are included, representing the respondents' viewpoints or acknowledging divergent perspectives.

Participants

Individuals agreed to participate in this study with the understanding that responses were confidential and anonymity would be protected. Respondents are described as a group, to illustrate the depth and breadth of their collective experiences. The eight participants (two female, six male) represented varied rural, suburban, and urban leadership experiences. All were Caucasian, and each had fulfilled school leadership responsibilities, serving as department heads, assistant principals, and/or principals. Six also served in district-level administrative roles, including superintendent, assistant superintendent, curriculum director, and student services director. Leadership experience averaged 20 years (range 11 to 33 years). Several had served in additional professional positions, including working in state education departments, county or regional school districts, and state administrator organizations. Seven held doctoral degrees in educational administration; the eighth had earned a master's degree in the field.

Participants worked in five public and two private universities across the United States. They ranged in age from the mid-40s to late-50s upon entering the professoriate, and their average entering age was 52 years. Five were drawing retirement pensions. Participants averaged 4.6 years in their current clinical appointments (range 2 to 11 years).

Job Choice Elements

Individuals' application decisions were influenced by several factors. Positions opened in the institutions at crossroads in their career paths: as three retired from administration, two concluded graduate assistantships, two had decided to explore new challenges, and one's position was eliminated. All had established working relationships with their departments prior to applying: All but one had earned degrees from their departments, and the other served on state committees with the faculty.

Six volunteered they were encouraged to apply. Participants adopted similar views of position quality when considering whether to apply. Reputation was important, as five valued institutional quality or the department's national reputation. Others embraced the departmental mission and values: One described a commitment to urban education, and another was proud of the department's ethical stance in preparing leaders. Five had aspired to teach at the university level, believing that their administrative experiences were an asset.

Clinical Faculty Role

In five institutions, clinical lines had been newly created in the past 10 years. One program developed clinical lines two years earlier, while this line was present in two universities for over 20 years. Seven explained their positions reestablished credibility with practitioners. Some observed that practitioner relationships in their departments had declined as fewer tenure-track professors with administrative experience were hired and as tenure-track faculty concentrated on building national reputations. One noted "the majority of the researchers here are doing their research pretty far away from here." Another said: "I believe the core value to primary activity at this institution is educational research, and I think teaching and service are second, are secondary to that research function. I think the field of practitioners is reacting to that."

Individuals perceived that they brought credibility because of their administrative experience and their positive working relationships with schools. One described his clinical role:

> Clinical folk tend to take care of business with respect to the university's relationship with the surrounding school districts. We are the ones that primarily maintain that network and develop the kinds of relationships that in the end work to the advantage of our candidates, of our students, whereas the tenure-track folk tend to have less exposure and, I think, probably the sense is less obligation as far as doing those kinds of things, given the emphasis on research and more national exposure for the program by the folks that tend to be in the tenure-track positions.

A closely related theme, shared by six, was the clinical field perspective that most of their tenure-track colleagues did not possess due to their lack of administrative experience. Clinical faculty, who were seasoned administrators, shared practitioner viewpoints and brought new energies to programmatic redesigns. One described this importance:

> I think that the faculty needs to hear the voice of the practitioner in designing curriculum, in designing for K–12 preparation, and even discussions about the nature and need for research and the university and, of course, the dissemination of that research.

The final theme disclosed an increasing emphasis on clinical components. All explained that field experiences now were required in their programs. Clinicians could supervise the internship experiences "rather than have tenure-track people take time from their research and writing responsi-

bilities to do the traveling." Administrative experience was stressed because "tenured faculty here didn't feel the connection with the field."

Clinical Faculty Position Structure

Participants were asked to describe how their positions were formally structured, including their title, length of appointment, compensation, and responsibilities.

Title and length of appointments. Clinical titles paralleled the tenure track in four programs: clinical assistant, clinical associate, and clinical full professor. Another used two levels—clinician and senior clinician—and the remaining programs used titles of visiting assistant professor and clinical instructor. One participant explained this position was an academic staff appointment, not a faculty line, in his institution.

Initial appointments were for 1-3 year terms, with clinicians eligible for reappointments. In two programs, clinicians could earn permanent appointments. Job security was appreciated by those holding multi-year appointments, although positions might not be renewed, should budget cuts be necessary. In such an instance, tenure-track positions would be protected and clinical lines could be eliminated: "If the money is not there, I'm not going to be reappointed and that's the bottom line." Another, who served in a series of one-year appointments, described his frustrations with this instability:

> Every year it was a struggle to get some kind of commitment. Would I be back next year? Well, I don't have the vaguest idea. I would start usually in March, February, "I'd like to think about next year, because if you don't want me here, I'll go get a job somewhere else." And usually it was August or September before I would have an answer….it was very tenuous.

Salary. Compensation was not a serious concern for clinical faculty drawing retirement pensions. However, salary was important to three, and differentiations of assistant, associate, and full ranks provided acceptable wages. One clinical associate explained, "I don't think I would have been able or willing to take a drastic pay cut if they would have brought me in at the assistant level." Two clinical associates were paid higher salaries than tenured associate professors. Clinical associate rank had been suggested for another but ultimately was rescinded because an untenured assistant professor (who was an experienced administrator) formally objected to earning a lower salary than a clinician.

Others acknowledged receiving diminished salaries as clinicians. One attributed his college's high clinical turnover rate to the lower salary tier. He intended to seek other opportunities because "there is no question in my mind that I could be out easily making double if not triple the amount of money I'm making here." Another, noting "I've been a cheap date," explained that clinicians earned the lowest salaries within his college.

Clinical responsibilities. With one exception, clinicians operated without job descriptions, and duties were assigned as needs emerged.

Clinicians taught courses, supervised field experience placements, advised students, and fulfilled service duties. Most held Graduate Faculty status and served as doctoral committee members. Those who could chair doctoral committees were uninterested in this duty, with one exception: In one institution, clinicians directed Ed.D. dissertations while tenure-track faculty directed the Ph.D. dissertations. Role divisions generally were clear: Clinical faculty did not conduct research and tenure-track faculty did not supervise clinical placements. One noted, "My interest is in teaching….I've done a lot of research but it's not my shtick, so to speak." They would be supported by their department if they chose to research and publish, but such activities would not advantage them for salary increases or for contract renewals.

Despite the research demarcations between clinical and tenure lines, three had published and three had given conference presentations. Rather than perceiving these activities as contributing to their department's research culture, they saw them as opportunities to collaborate with their tenure-track colleagues. However, one noted his department had redefined the research expectation for clinicians to include presenting at practitioner conferences, rather than at more scholarly venues. Another explained: "While I don't have the responsibility to do it, I just feel that it is positive to do it." Due to his program's national ranking, another shared:

> I think that there are informal pressures because I have become involved with projects that involve other professors and, of course, they want to publish and they want to use the work for their own career advancement. So, I can feel some pressure.

Five explained they had assumed leadership responsibilities as their positions evolved over time. One had served as department chair, another assistant department chair, two coordinated their leadership preparation programs, and another coordinated the clinical experiences program. All served on departmental, college, and university-wide committees. Other service included assisting with writing accreditation reports, recruiting students, developing brochures, training mentors, and providing assistance to adjuncts.

Status and Value of Clinical Positions

Clinicians were asked how their contributions were perceived and valued by their colleagues. Differences existed, depending on whether their status and contributions were considered within their departments or at the university level.

Departmental status. When they initially were hired, most clinicians perceived they might be treated as "stepchildren" or "second-class citizens." They unanimously affirmed feeling welcomed by their departmental and college-level tenure-track colleagues, but they did acknowledge some equity and equality concerns. One noted, "I don't know if I'd use the word 'treatment.' Certainly, 'perceived.' There is no question that we are perceived differently." Several described a pecking order with clini-

cians at the bottom of the faculty hierarchy. One recited a tenured colleague's off-hand comment that "an assistant tenure-track faculty member probably, in reality, outranks an associate clinical faculty member."

Despite an accepting climate, the expectations for faculty research did create departmental tensions. One described an implicit understanding of "research being valued more than directly intervening in practice." A second reported "hearing a colleague say I don't have any responsibility to produce anything as a scholar." Another described "a stigma attached to clinicians, especially at a Research I university, where the value of research is great." Another noted his program's practitioner focus conflicted with the institution's goal to become an elite research university, with the feeling "that somehow an Ed.D. degree is second-class."

These individuals occasionally felt undercurrents related to status. Noted one, "There are times when as a clinical you feel that people talk about you as if you were not in the room." Another observed, "We tend to be fairly careful and conscious of what we say and how we speak." Another stated he could not refuse additional duties because of his status. Yet, due to their extensive experiential backgrounds that many of their tenure-line colleagues lacked, others said they could deflect criticisms and they would not hesitate to voice their opinions. Three noted their faculties had held conversations about tenure-track and clinical faculty relationships so they could reach a consensus on their collective responsibilities, contributions, and benefits.

Status beyond the department. When their roles reached beyond the college, however, these individuals explained they often were not received as equals. One explained he did not feel valued "when my involvement has gone beyond the department and even beyond the School of Education. Once it gets beyond the School of Education, then I guess I would say I kind of feel like 'dog meat.'" Another was not allowed to present a proposed curriculum revision to a university-wide committee due to his clinical status, even though he created the program:

> I was not invited to that. That was the Dean of the School of Education, and my department chair, and basically I was told for political reasons at that level people only care what the Dean thinks.

Another recalled being asked questions by tenured faculty outside his department "to put me in my place." He summarized his experiences: "In a way, sometimes I've felt welcomed, sometimes I've felt tolerated, but I've never felt ignored. I've never felt that I was a peer. I never expected to be a peer; I've expected to be a colleague."

Adjusting to the University Culture

Clinical faculty, who were used to school leadership positions, experienced some adjustments with role socialization and the university culture. Adjustments included adapting to new work schedules and understanding the university governance structure.

Work schedules. A common theme was acclimation and socialization into the university culture, in relation to flexible working conditions, faculty autonomy, and decision making. Four explained they were accustomed to an administrator's demanding work schedule and experienced difficulties adapting to a culture in which faculty were only infrequently in their offices. Shared one:

> When I first came here and asked what my hours were, the Associate Dean laughed at me. When I asked how many days he expected me to work here, he laughed again and said, "You're not an administrator any more; you're a faculty member." But I have to tell you that I still find it difficult to do.

Another enjoyed giving up his 14-16 hour workdays: "My stress level is down by 1000%, my working hours are down by 50%, and I'm sitting here looking at these folks saying, 'Why didn't I discover this 25 years ago?' This is the life!"

University governance system and faculty autonomy. Although enjoying job flexibility, clinicians were amazed by the organizational structure, which they variously described as "medieval," "ancient," and "hierarchical." As she learned how a proposal traversed through the governance system, one observed, "Will you just tell me which chimney I'm watching the smoke come from? This resembles the Catholic church." As experienced school leaders who are used to making immediate decisions, they sometimes were frustrated over the slow pace of decision making and with faculty autonomy. Faculty debates often were viewed as wasted energy because even decisions "like where we should hang a bulletin board in a hallway sometimes become irresolvable." Explaining the university culture values academic freedom over teamwork, one provided this insight:

> The Dean actually made a joke, telling me humorously when I came here and asked how many people work here and how does it work? He said, "Well, there's 60,000-some people and students that are involved here, and there's only one rule: Never tell anybody what to do."

The faculty autonomy and work flexibility equated to isolation for one clinician:

> In my old position I would meet 300 people a day….Now, three is a good day. I reached out, initially. I had food in, I'd stop people. I tried soft music coming out of my office just to put some noise on the floor, some pleasant life. I literally stopped a gentleman one day and said, "I'm (name), I'm new, I'm trying to reach out to people. I know you don't need me, I need you. I'm the new kid on the block. I've got some sweets in here if you ever want to stop." And he said, "Lady, I'd really like to, but I'm the FedEx guy and I don't get in here very often."

Policies and Clinical Faculty Effectiveness

University policies can facilitate or hinder work productivity, and these individuals identified benefits and constraints. Universities with

long-standing clinical appointments in other disciplines across the university campus tended to have formal policies and practices. One clinician in a newly created position observed, "Had we not had that strong evolution and development of the program because of the other colleges, then I think this would be a lot messier here and much less defined." Another explained, due to his persistence in advocating for clinical faculty rights, "over a period of time we became pretty much not equal partners, but pretty close in terms of governance." The majority expressed satisfaction that policies permitted their representation within their departments and on university committees.

When policies restricted clinical involvement, faculty creatively resolved problems. For example, one explained how he was allowed to direct a student's thesis:

> One of the tenure-track folks said, "Here's the deal. If you're willing to take this guy on, because he's working in an area that you've had some experience in, we'll list us as co-chairs of the committee, if you're willing to do most of the work." And I said, "Yeah, I can do that." So, you bend rules where you can…

Instances arose when policies limited clinical participation, as one noted: "the policies seem to be the cruelest piece of all." Another discovered a recent university handbook revision inadvertently had eliminated policies related to clinical faculty. Three stated policies did not permit them to chair student committees. Another noted, although he was a former superintendent, he could not teach superintendency courses because they were considered to be courses above the master's level. Others explained prohibitions ranging from applying for grants to requesting departmental travel funds.

Voting was raised by many participants, as the exemplar of involvement in faculty governance. All noted they could vote on most faculty decisions, but there were certain occasions in which they were ineligible. Explained one:

> I think everybody understands why that is, but that is always a little bit uncomfortable. Or every now and then I find myself saying something and someone says, "I don't think that's right," or "I don't think you can do that," or "I don't think you can make that decision because you're clinical." And every time I hear that, I think that the word "just" is in the sentence. You know, "You're just clinical."

Discussion

This study illuminated several themes that warrant further discussion. First, the profiles of these clinical faculty members differed from recent descriptions of tenure-track faculty members. Their average age of entry into the professorate (52 years) is substantially higher than the mean age (38 years) of entering tenure-track professors identified in the McCarthy and Kuh (1997) study. All had administrative experience, in contrast to lower percentages of tenure-track faculty with administrative experience (Levine, 2005; McCarthy & Kuh, 1997).

Job choice theory was an appropriate framework for this study because it appears to "predict job intentions for graduates who have already entered the educational leadership professoriate" (Pounder et al., 2004, p. 522). The objective elements of job choice theory did not appear to be a primary consideration, as these individuals did not describe financial incentives when noting their attractions to their positions. However, three mentioned that they could not afford to accept a clinical position involving a significant salary reduction. The other five individuals were earning retirement pensions, supplementing any salary reductions resulting from clinical appointments. The subjective element of job choice theory appears to be closely aligned with these participants' decisions to accept these positions. Several described their positions in psychologically motivating and satisfying ways (Behling et al., 1968), explaining that they were attracted to apply for their positions because of their programs' missions to serve aspiring leaders. Others explained they had reached crossroads in their careers, prompting them to teach at the university level and influence the next generation of school leaders.

The critical contact component of job choice theory provides interesting perspectives. Unlike elements related to limited information regarding the position (Schwab et al., 1987), all possessed extensive knowledge about their departments when they applied, and all noted job responsibilities were closely aligned with their expectations. Pounder et al. (2004) hypothesized that individuals who decide to apply to professorial positions already have experienced role socialization, but this was not fully the case with these participants. They experienced some adjustments when settling into their positions, particularly relating to understanding and operating within the university culture, adapting to new work schedules, and understanding faculty autonomy issues. Although they displayed some understanding of the responsibilities inherent in their new positions, they generally were not fully prepared for the cultural adjustments they would need to make to become socialized into their positions.

These clinicians perceived they served a distinctive purpose: ensuring practitioner credibility and supervising field experiences. Yet, when analyzed against the Griffiths et al. (1988) field specialist description, the emphasis on field-based research is lacking. Rather than complementary tracks with clinicians conducting applied research and tenure-track faculty addressing scholarly research, with one exception, these departments have adopted a model in which only the tenure track is afforded time for research. Several expressed an interest in conducting applied research, publishing in applied journals, and presenting at practitioner conferences, but they stated that time must be provided to support these activities and it currently was not provided for them.

The perceived status of the clinical faculty position deserves additional commentary. All individuals expressed satisfaction with their positions and fully embraced their responsibilities. Yet, although they believed they enhanced their departments' field credibility, they perceived their clinical appointments—paradoxically—diminished their credibility in their universities. The effect of university policies and practices was that

their roles and responsibilities had been narrowly defined into the areas of teaching and service, and research institutions typically value research activities over these two areas (Levine, 2005). Consequently, they perceived that they held low status within their departments. Job descriptions often were nonexistent and most of them annually negotiated their responsibilities. When university policies permitted it, some were successful in negotiating appropriate levels of compensation, as well as gaining some degree of permanency to their posts.

Recommendations

According to Griffiths et al. (1988), "…the roles in departments of educational administration need to be differentiated by both scholarly focus and responsibility for the many aspects of a professional preparation program" (p. 300). This distinction may be more apparent in major research universities than in institutions that traditionally have emphasized teaching over research (Hearn & Anderson, 2001) because faculty in teaching institutions often conduct research that is more applied in nature and more often employ professors with administrative experience (Levine, 2005). Clinical lines can be helpful in expanding programs' practical orientations and field-based connections, while permitting tenure-track faculty to continue to emphasize theory building and scholarly research activities. Through appropriate differentiation of responsibilities throughout the theory-to-practice continuum, clinical and tenure-track faculty can effectively serve the needs of practitioners and the research community. Information gained from this study yields the following recommendations for programs with existing full-time clinical positions and for faculties considering creating these lines. These recommendations may be more applicable to educational leadership programs in major research institutions and for institutions that are experiencing a disconnect with practitioners.

1. *Educational leadership programs should engage in sustained dialogue regarding clinical faculty responsibilities, including expectations to engage in field-based research*. Only one of the individuals in this study operated with a formal job description; consequently, responsibilities for the remaining participants shifted according to departmental needs. It would be helpful for departments to formally articulate the clinical position responsibilities, including applied research activities, so position expectations could be incorporated into the overall faculty model in such a way that clinical faculty and tenure-track faculty are fully apprised of their collective responsibilities to serve the needs of their institution and constituency. Clinicians engaging in research would benefit the field (Young et al., 2002) and enhance the department's status, as they would be viewed by practitioners as being involved in schools and contributing to the knowledge base. By presenting at practitioner conferences and publishing in practitioner outlets, clinical faculty would increase the visibility of their educational leadership programs. Also, because they would be engaged in research, the status of clinical faculty would be enhanced within their institutional settings.

Their participation in field-based research also would assist clinical faculty in developing essential skills to serve as participating members of doctoral committees, as well as serving as student advisors. Such activities also would bring their participation into more complete alignment with the professional school model.

2. *Departmental and university policies should be developed, acknowledging the unique role and responsibilities of the clinical position*. Consideration should be given to ensuring that clinicians are integrated into departmental and university governance systems and are provided the authority to vote on appropriate institutional matters. Unlike tenure-track appointments, clinical lines in some institutions do not afford job security or provide a mechanism for attaining some levels of permanency in their appointments. Departmental and university policies would be helpful in enhancing the job security and status of clinical faculty, empowering them to be more effective and productive institutional members.

3. *Institutions should consider the development of tiered salary structures that acknowledge the experiential backgrounds of clinical faculty*. Clinicians in this study who did not express salary concerns tended to be earning retirement pensions; individuals who had not retired from administrative careers resisted entering clinical appointments at the cost of dramatic salary reductions. The development of assistant, associate, and full clinical tiers, similar to the tenure-track, would be a positive mechanism to recruit mid-career professionals into the professoriate and to appropriately compensate them for both their experience and for their increased expectations to engage in applied research. Young et al. (2002) agree: "…the inclusion of more faculty members with practical orientations necessitates changes in how entry-level salaries and professorial status (i.e., assistant, associate, or full professor) are determined" (p. 144).

Conclusion

Levine (2005) recently was highly critical of educational leadership program quality, voicing concerns related to clinical experiences and the lack of administrative experience of professors. Prior to this report, Pounder et al. (2004) foreshadowed that the profession is at a crossroads yet noted "this can be a time to reinvigorate the professorate to make it more attractive to a diverse and exciting group of new professors" (p. 525). Full-time clinical appointments represent a credible response to Levine's criticisms.

This study provided observations related to why individuals chose to become clinical faculty members in these programs. It also provided their views on how their roles and responsibilities can enhance program effectiveness. Clinical faculty participating in this study perceived that they brought credibility to their programs and helped to reinvigorate relationships between practitioners and program faculty. They provided a practitioner perspective to departmental conversations, and they were able to facilitate theory-to-practice connections for their students. Although

they expressed concerns related to their status within their institutions, these concerns were not insurmountable. As educational leadership programs begin to incorporate more field-based elements, it will be interesting to learn whether more programs create clinical faculty lines, and, if so, whether position responsibilities will evolve to include requirements and time allocations for applied research.

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